Hutchinson Clinic Patient Financial Policy

Patient's Name: «PName» Patients DOB: Patient's MRN: «PNumber»

Thank you for choosing Hutchinson Clinic as your health care provider. We are committed to providing you with quality and affordable health care. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Please understand that payment for services is a part of that relationship. Please ask if you have any questions about our fees, our policies, or your responsibilities. It is your responsibility to notify our office of any patient information changes (i.e. name, address, email, phone, insurance information, etc).

1. INSURANCE We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. In order to properly bill your insurance company we require that you disclose all insurance information including primary and secondary insurance, as well as, any change of insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. We will bill your insurance company as a courtesy to you. Knowing your insurance benefits and deductible is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. **CO-PAYMENTS AND DEDUCTIBLES**. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered a breach of contract with your insurance company or government payor such as Medicare. . Please help us in complying with our contractual obligations and government regulations by paying your co-payment at each visit.

3. **NON-COVERED SERVICES** We will bill your insurance company as a courtesy to you; however, not all insurance plans cover all services. In the event your insurance plan determines a service to be non-covered or not considered reasonable or necessary by Medicare or other insurers, you may be responsible for the complete charge for the services you received. All procedures billed in this office are considered covered unless limited by your specific insurance policy.

3. PROOF OF INSURANCE All patients must complete our registration process before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim. Patients without insurance coverage, patients covered by insurance plans in which the office does not participate or is out of network, or patients without an insurance card on file with us are considered private pay accounts. It is always the patient's responsibility to know if our office is participating with their insurance plan. If there is a discrepancy with our information, the patient will be considered private pay unless otherwise proven. Private pay patients will be required to pay the estimated balance in full before any appointment.. Upfront estimates are only an estimate and you may receive a statement for additional services. We accept cash, check, and all major credit Cards. A preferred payment plan is to have balance paid in full within 6 months. Extended payment arrangements are available if needed; you may incur an administrative fee to utilize these services. Please ask to speak with the Central Business Office to discuss a mutually agreeable payment plan.

4. **CLAIMS SUBMISSION**. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

5. **COVERAGE CHANGES** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim, the balance will automatically be billed to you.

6. ***NONPAYMENT****:* It is our office policy that all past due accounts be sent two statements. If payment is not made on the account, a single phone call will be made to try to make payment arrangements. If no resolution can be made, the account will be sent to the collection agency or attorney, and may result in possible discharge from the practice. In the event an account is turned over for collections, the person financially responsible for the account will be responsible for all collections costs including attorney fees and court costs. Regardless of any personal arrangements that a patient might have outside of our office, if you are over 18 years of age and receiving treatment, you are responsible for payment of the service. Our office will not bill any other personal party.

7. **ACCOUNTING PRINCIPALS** unless otherwise specified patient payments and credits are applied to the oldest charges first. Insurance payments are applied to the corresponding dates of service. We reserve the right to reallocate visit copays causing account credit to any service date on your account.

8. **RETURNED CHECKS** will incur a $30.00 service charge. You will be asked to bring cash, certified funds or a money order to cover the amount of the check plus the $30 service charge to pay the balance prior to receiving services from our staff or the physicia*n.*

9. ***PARENTS of PATIENTS****: By signing below, you acknowledge that you are responsible for the payment of services received by your minor child. It is your responsibility to provide proof of valid insurance as required under paragraph 3 above. While we may submit bills to the insurance company for the parent/guardian who maintains the insurance policy for the minor, both parents are legally responsible for the payment of services provided to your minor child. It is the parents' responsibility to communicate with each other regarding any billing matters that may be paid by another parent or guardian as a result of a court order or custody matter.* ***RESPONSIBILITY FOR PAYMENT****:* Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Signature of **Patient, Parent or Guardian** (circle one) Date